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THE OBVIOUS AND THE PLATITUDINOUS

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This address will deal with the obvious and the platitudinous.

A year or more ago the writer was asked by one of his colleagues to see a rather small and slender elderly woman whose only complaint was a big stomach. A big stomach in a small, slender woman is the most obvious and platitudinous thing imaginable. Her recent history revealed that some months previously a New York surgeon had removed a benign umbilical cyst. He told her that she was too fat and should reduce her weight, her stomach was too big. She consulted a physician who, she was told, was very successful in reducing big stomachs. He told her that for her height she was fifteen pounds overweight and put her on a diet which failed to reduce her weight appreciably. Her family physician was called to see her for some minor intercurrent ailment.

His examination revealed a transverse abdominal scar, absence of the navel and the aforesaid big stomach. It was obvious and platitudinous. Not being a surgeon or a specialist in obesity he had no preconceived notions as to the nature of the big stomach, and as I have said, called in the writer who removed a large ovarian cyst and by a twist of the wrist, as it were, cured the big stomach and brought the patient's weight to normal.

The moral of this McFaddenesque true story is that even the obvious and the platitudinous occasionally deserve our attention.

Through the years, especially the last fifty years, the character of the practice of medicine has gradually changed. I refer, today, not to the science or the art of curing and preventing disease but to the relationship of the individual physician to his patient, to his individual fellow practitioner, to the body of physicians usually known as organized medicine and to the state. Before the passage of medical practice acts no degree conferred by an authorized medical school was required before anyone could hang out his shingle as a physician. Even after medical practice laws were enacted, the requirements if judged by modern standards were very lax. As the requirements for a license have been stiffened at the insistance of the medical profession the various irregular cults have made successful attempts, by way of the back door, to nullify to some extent the protection of the public which the medical practice acts were designed to promote. At the time these acts became law it seemed as if the medical profession had won a decisive victory. Time has shown that while a victory, it was not decisive and that as long as the public and especially the legislators look at the right to practice medicine as a privilege conferred by the state and fail to realize that all medical legislation is designed primarily to protect the public, so long must the medical profession be ever alert to scrutinize every legislative bill that may affect the public health.

It is a far cry from the day when the state assumed no responsibility for the health of the individual citizen and very little for the public health, when quarantine was almost the sole medical function which it assumed and the actual care of the sick was left to the family or to charity. Not only does the state assume the duty of protecting the public by pure food and drug laws, by regulation of the sale of narcotic and other dangerous drugs, by compulsory vaccination, by pre-marital physical and laboratory examinations and a multitude of health measures, protective and preventive, but it has in these latter days accepted the care of the more or less indigent individual patient as one of its responsibilities. This brief summary indicates the fundamental change that has taken place in the relation of the state to preventive medicine and the actual practice of the healing art.

Equally great have been the changes in the relation between the individual patient and the individual doctor. The old family doctor who could diagnose and treat any disease was well as the next man is no myth. The body of scientific knowledge was so restricted that one man could master it. Today it is so large that no man can hope to have more than a superficial acquaintance with vast fields of medical science, which perforce have been allotted to medical specialists.

Economic necessity, fully as irresistibly as the broadening of medical knowledge, has inevitably altered the relation of doctor to patient. Well within the memory of men still in active practice the only equipment necessary for the graduate in medicine who was starting in practice was a sense of touch, one good eye, one good ear and an educated nose supplemented by a watch, a clinical thermometer, a stethoscope, a few surgical instruments, an alcohol lamp and a few test tubes and chemicals. If he was particularly well provided, he had a microscope and a blood counting apparatus. The eye, somewhat later combined with ear, nose and throat, was the only recognized field for the specialist.

With the multiplication of mechanical and laboratory aids requisite for the refinements of modern diagnosis and the constantly growing expense of physical, chemical and biological aids to treatment, the profession was forced to pool not only its knowledge but its physical equipment and the era of the specialist was upon us.

With the principle accepted that every patient, no matter what his economic status, must have the best in diagnosis and treatment the problem has become increasingly complex. Even with the pooling of resources resulting from the development of specialization, the expense of accurate diagnosis and adequate treatment is prohibitive for a large fraction of patients who cannot be classed among the indigent. Group medicine and a vast increase in the number of patients treated in hospitals resulted and was in fact a further pooling of resources in which not only the doctors but the patients themselves as represented by the public participate. And the end is not yet. More and more the practice of medicine will be dominated by organized forces outside of the profession. Up to the present time in Rhode Island at least, that domination so far as the individual doctor and his patient are concerned has been exerted predominantly by privately endowed and unselfishly administered hospitals. How beneficent for both doctor and patient that domination has been can be appreciated only if one tries to imagine what the practice of medicine would be like if suddenly all hospital facilities were wiped out. Beneficent as it may be, the rise of specialism, the concentration of diagnostic and therapeutic facilities in hospitals and clinics and the ever increasing tendency to shift the responsibility for the care of the sick to the state, have already and will continue to raise problems that must be solved, if they are to be solved wisely under the guidance of the medical profession.

As the relations of the individual physician to the state and to his patients have changed, has there been a corresponding change of the relation of physicians one to another? In the old days, when the individual doctor treated directly with his patient and his fellow practitioner, a strict adherence to the golden rule was all that was necessary for peace, justice and happiness in the cult of the healing art. Is that sufficient today? Obviously not. The status of the anesthetist, the radiologist and the pathologist, so forcibly brought to our attention in connection with the rise of hospital service insurance plans, is a case in point. The problems raised by the increasingly intricate organization in the field of medicine cannot be solved by the individual physician but must be solved by a strong organization, sometimes furthering and sometimes opposing current trends.

The medical profession throughout the country is thoroughly organized. The American Medical Association, the state medical societies and the county medical societies have been in existence so long that the medical profession has come to take them for granted and look upon them as something imposed upon them by fate — whether a beneficent or a malign fate depends upon the point of view. It cannot be emphasized too often that organized medicine is what the individual members of the profession have made it. Far from being run by a clique and failing faithfully to represent its members, it is thoroughly democratic. When the American Medical Association speaks for the profession it says what the state societies have ordered it to say. It has no voice of its own. It merely records and reproduces the voice of the state medical associations. Its governing and vocal

body is the house of delegates and the house of delegates is composed of representatives from the state medical societies which have delegated their representatives to speak for them. Any individual or group of individuals which criticises the pronouncements of the American Medical Association is criticising not the pronouncements of a small autocratic group within the profession but the pronouncements of the elected representatives of the state medical societies. It is imperative therefore that the state societies should speak only after free discussion and mature deliberation.

The American Medical Association speaks for the profession. Its critics speak as individuals. This is not to say that the American Medical Association may not at times be wrong and its critics right. Neither is it to say that no individuals or groups of individuals should criticise the pronouncements or policies of the American Medical Association. On the contrary any individual who believes that the American Medical Association is wrong, should in loyalty to the profession make every honorable effort to correct what he conceives to be a mistake. If he can persuade his own state society that a mistake has been made and through its delegate a majority of the national house of delegates his view will prevail. It is only by the road of constructive criticism that progress can be made.

The American Medical Association is often spoken of as the "parent association." It is no such thing, it is the creature and servant of the state associations.

The state associations (in this state the Rhode Island Medical Society) are the creatures and servants of the local or county societies. They can speak and act only as they are directed by the local societies through their representatives in the house of delegates. They have no voices and no initiative of their own. They must take orders; they cannot give them. They may make recommendations but cannot enforce them. The local societies are the foundation on which the whole superstructure of organized medicine is built. They are all powerful. The opposition of the medical profession to the Wagner Act as voiced by the house of delegates of the American Medical Association on May 17, is not the policy of the American Medical Association as such but rather is the policy of the county medical societies as voiced by their duly elected representatives.

The opening sentence of this address was a threat that it would deal with the obvious and the platitudinous. I think I have made good that threat. One more platitude and I am through with generalizations.

The Rhode Island Medical Society throughout its history of one hundred twenty-eight years has fostered high professional ideals and been an inspiration to self-improvement among its members in the art and science of healing. This building is a silent witness to the unselfish labors of past members most of whom are no longer among us. The library which it houses testifies to the scholarly ideals of past and present members. Its reading room shelves are stocked with the leading magazines of this and foreign lands. Throughout its long life it has unselfishly approved and promoted any movement which, in its judgment, would promote the public health or further the scientific attainments of its members. But times have changed. No longer can we practice medicine, shaping our relations with our patients and our fellow practitioners with no other guide than allegiance to our Hypocratic oath. No longer is the state content to leave us to our own devices, trusting to our interest in the public welfare and our devotion to our patients. The increasingly complex organization of modern society must inevitably affect the medical profession and if it is to be a leader and a guide in medical affairs, organization must be met by organization that as a militant body it may wield an influence that as individuals it can never hope to wield.

First in importance is a better understanding on the part of the constituent societies of the functions and potentialities of the state society. As has been pointed out, the local societies are the foundation on which the whole superstructure of organized medicine is built. From them must come the inspiration and initiative. Only thus can the work of co-ordination by the state society be effective. From Westerly comes a plea for a medical lien act. From Pawtucket a protest against the treatment of accident cases among W.P.A. workers in government hospitals. These and similar matters from other societies are proper subjects of consideration by the state society. The Providence Society, it seems to me, has pointed out one way by which greater co-operation by the local society may be accomplished. At the invitation of their president, the presidents and secretaries of all the other societies

met and discussed various problems that confront the state society. It was a very stimulating meeting. I suggest that a committee on co-ordination be appointed to consist of the presidents and secretaries of the constituent societies and the president, vice-presidents and secretary of the state society to meet at least twice a year, once in the early Fall and once in the late Winter or early Spring. At these meetings suggestions from the local societies could be entertained and problems which came up for discussion transmitted to the local societies by their own representatives. More intelligent discussion in the local societies would result from such a procedure than from a formal communication sent by the secretary of the state society.

During the last year the Committee on State Policies of Public Health made a strenuous but unsuccessful attempt to have a Doctor of Medicine with a degree of Doctor of Public Health and experience in public health work appointed State Director of Public Health. The Legislative Committee worked hard to have a Basic Science Law enacted by the Legislature. It was passed by the Senate but died in the House Judiciary Committee done to death by the political pressure brought to bear on the politicians by the osteopaths and chiropractors. There would seem to be but one answer to the question why the medical profession, though out-numbering these cults nearly ten to one, fail year after year to overcome their opposition to any measure of which they disapprove. They are organized and we are not. There should be committees in each local society corresponding to the committee of the state society who could be called upon to co-operate with the state society in bringing pressure to bear on their local senators and representatives. Pressure from back home is the only really effective pressure.

Effective organization means continuity of policy and effort. The president changes every year. Unless my own experience is unique, it takes him a year to learn what it is all about. In the past, continuity has been attained by continuing the secretary in office as long as he would consent to serve. In the good old days this sufficed. While serious problems occasionally had to be solved, for the most part his chief duties consisted in sending out routine notices, seeing that the president appointed committees at the proper time and getting speakers for the scientific meetings. If he had a secretary in his office she could do all the necessary clerical work for him with little or no expense to the society. Any effective campaign which the society may undertake whether legislative or educational entails an amount of work which cannot be done without more clerical assistance than has heretofore been available. Recently the worker who has been engaged in making a catalog of the library was dropped by the W.P.A. which had been paying her salary. Funds were available in our treasury to retain her in her present position and her services as a clerk are now available to the society. We hope that with this assistance available, the secretary may be relieved of some of the routine details of his office and his available time spent in more constructive work. She can be of great assistance to the various committees upon whom most of the actual work of the society devolves. The editor of the Journal has urgently needed assistance which such a secretary can give. The Journal is also in need of financial assistance which it has never had from the society. A few dollars invested might be returned in profits from increased advertising. It probably is a wise policy to keep sufficient funds in the treasury to meet unpredictable emergencies but after all the society collects its dues to be spent for the benefit of the society and I for one, do not believe that if a serious emergency arose the members would not meet that emergency. I refuse to believe that the spirit of loyalty and co-operation that is expressed in this building and the library that it houses is dead. If it is, the society does not deserve to survive.

Be that as it may, there is no gainsaying the fact that the work of the society is limited by its lack of funds. Telephone calls, correspondence, typed reports which go to the secretaries of the constituent societies, mimeographed reports which should go to the individual members all take money as well as time. The only two ways by which our income may be increased are by increasing the membership or increasing the dues or both, probably both. Many members of the local societies are not members of the state society. All should be. The present dues are insignificant as compared to club dues or labor union dues. I do not know what the American Medical Association has spent in protecting its members from political assault but I venture to say that it is picayune as compared to the C.I.O. contributions in the last presidential campaign.

This is not the place to discuss the details of how our income shall be increased. The final responsibility is the council's.

I have pointed out that the state society is the creature and servant of the local society. Whatever the local societies demand be done, it must do. The local societies speak through the house of delegates and the council. The house of delegates for the past year at least has been almost if not quite inarticulate. The reason is not far to seek. The notice of the meeting states that the council will meet at four-thirty; the house of delegates at five. The council meets behind closed doors, deliberates and adjourns whenever the spirit moves. The house of delegates is called to order, not at the appointed hour of five but at five-thirty or later. The minutes are read, the treasurer makes his report. Interesting and highly important committee reports are read. All this is proper, necessary and enlightening but by the time the item of new business is reached it is getting on toward seven o'clock. The members who have made the effort to come from Westerly, Newport and Woonsocket have cooled their heels in the reading room for perhaps an hour waiting for the council to adjourn. By the time the routine business has been finished, any initiative, any desire to start something has died and the meeting adjourns. The house of delegates and the council should not meet on the same day.

One more suggestion and I am through. The constitution sets a specific date on which the annual meeting of the council and the house of delegates and the date on which the scientific meeting shall be held. This year our secretary was unable to be present at the annual meeting of the council and house of delegates. He was in St. Louis representing this society. Inflexibility in the date of the scientific meeting hampers the committee in getting desirable speakers. A change in the constitution giving the committee more latitude in this matter is desirable.

I have brought to your attention the needs of the society at this meeting which has no power to act upon them because I believe that only by acquainting the individual members of the society with the problems which confront us can those needs be met. That this society has not had prophetic vision and planned its campaign against the assaults upon the profession by hair brained and irresponsible political reformers is obvious. There has been an occasional prophet of evil but they have been voices crying in the wilderness. We need not blame ourselves too bitterly for that is always true of prophets. Now that the emergency is upon us the profession is awake. The presidential address of the one hundred twenty-eighth meeting of the Rhode Island Medical Society is a plea that it shall assume its full responsibility in the fight that is ahead of us; that it shall not sit back expecting the American Medical Society to do its fighting for it. It is a plea also that the local societies be not content merely loyally to support the state society as they have always done in the past, but move vigorously to stimulate it to more effective effort.

PHYSICIANS AS ARTISTS

"From time immemorial, medicine and art have been closely associated. The same skill that makes the surgeon's fingers deft with scalpel and ligature is at work in the beautiful examples of sculpture and carving shown in this book. The eye that so quickly and accurately evaluates the gradations in color and texture between normal and pathologic tissues coordinates the hand that wields the painter's brush. The man who chooses medicine as his life's work is largely motivated by a love for his fellow man, else he would select a vocation offering greater monetary reward. From the beginning, he is trained to exercise his powers of observation, and in time develops imagination, sympathy, understanding, philosophy and reverence, all of which are the very essence of art. Morever, he deals with that most exquisite form of divine art and beauty, the human body.

"At the least, every physician is able to develop a sensitiveness to and an appreciation for fine art. He can also cultivate a hobby which if not one of the fine arts, is in the class of 'work by the side of work.' Dr. Charles A. Dan, who has always stressed the value of cultural medicine, has advised: 'Be a collector, for example, of stamps or automobiles, or old books, or neckties or pins; or find diversion in some collateral branch of science; the lore of birds, of fishing and shooting. Make a garden or cultivate shrubs and flowers. These kinds of activities will make your life happier and your professional character more attractive and effective.' "

— quoted from "Parergon," published by Mead Johnson & Company, Evansville, Ind. Free copy available on request.

THE TREATMENT OF PNEUMOCOCCUS PNEUMONIA WITH SULFAPYRIDINE

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Not since the time of Ehrlich has chemo-therapy received such a stimulus as when Dogmak in 1935 announced a new chemo-therapeutic agent. This agent he found effective in the treatment of experimental streptococcal infections in mice and also moderately effective against pneumococcal infections, particularly those due to type III. His original preparation was an azo dye called Streptozon or Prontosil. Other workers found that the activity of the drug was due to the part containing the O=S=O radical. This fraction, which was separated, was called Sulfanilamide. Various other related compounds were tried by other workers but were discarded because of their high toxicity. Kolmer in 1937 tried various pyridine compounds with favorable results in streptococcal infections but not as good as when sulfanilamide was used.

Since sulfanilamide was put on the market, scattered reports have been appearing in the literature concerning its effectiveness in pneumococcal infections, but these results have not been startling. In the spring of 1938 an article appeared in the Lancet[1] concerning a new drug for treating pneumococcal infections. The preparation had been found by two English workers, Ewins and Phillips, to be the most effective, of a group which they had studied, in the treatment of experimental pneumococcal infections. The drug was called M & B 693, Dagenan or 2 (P-amino-benzene sulfanamide) pyridine. Whitby,[1] who reported the experimental work, found it to be therapeutically active in mice against pneumococcal infections, particularly types 1, 2, 3, 5, 7, and 8. Since that time clinical reports have appeared in English literature and more recently in the American literature.

This drug has a formula in which pyridine has been combined with sulfanilamide. One of the H's has been replaced by a pyridine radical. It is a white crystalline almost tasteless powder, soluble in water at ordinary temperatures to approximately one part in 1,000. The drug, according to Whitby[1] and Wein,[2] has a low toxicity for animals. Whitby[3] in a later article stated that, in spite of its relative insolubility, the drug was rapidly absorbed, even more rapidly than sulfanilamide, but it was excreted somewhat more slowly than sulfanilamide. In the same article he stated that the maximum blood level was obtained in twelve hours, that the blood contained no drug twenty-four hours after treatment had ceased but the urine contained traces for forty-eight hours. Long[4] does not agree with Whitby[1] in all of these statements. He thinks that the low acute toxicity for animals results from the fact that very little of the drug is absorbed. Also that the drug is irregularly absorbed in man and animals and in comparison with sulfanilamide is more slowly and less well excreted. He found that concentrations in the blood following a single dose are better sustained than with a comparable dose of sulfanilamide.

The bulk of the drug seems to be excreted through the kidneys in two forms, free and acetylated. Long[4] found that on a single dose of .05 to 0.10 grams per kilo of body weight, 39-79% the drug was excreted in the urine in from 3-4 days. Barnett[5] et al recovered 54-59% in the urine in a patient on a constant intake of the drug.

The drug seems to be able to pass freely into the body fluids from the blood stream; it has been found in high concentration in them. Long[4] stated that from ½-¾ of its concentration in the blood may be found in spinal fluid or exudates. Barnett[5] seems to think that it remains for a long time in these body fluids.

Once in the blood stream a certain percentage is changed, apparently by the liver, into an inert compound, by a process of acetylation. Both the free and acetylated forms are found in the blood and urine. The two forms are determined by the same colorimetric methods as for sulfanilamide. The amount of the free form found in the blood by various workers has varied from a fraction of a mgm. to 23 mgm. % However most of these workers feel that the blood level is of no significance in predicting the outcome of the infection. This is due to the fact that just as good results have been obtained with low levels as with high ones. With the usual dosage employed levels of from 3-6 mgms. % are obtained. Thus it differs from sulfanilamide where at least 10 mgms. % is necessary for good results.

From the Medical Service of the Memorial Hospital, Pawtucket, R. I., John F. Kenney, M.D., Chief.
Read before the Pawtucket Medical Association, April 20, 1939.

The mode of action of the drug as in the case of sulfanilamide has not been definitely settled. Whitby[1] states that the drug acts by bringing about degenerative changes in the capsular material of the pneumococci. Telling and Oliver[6] believed that they confirmed this. Fleming[7] and Long[4] have been unable to find specific changes in the capsules of pneumococci observed in peritoneal exudates. These workers noted that multiplication of susceptible organisms is hampered both in vivo and in vitro following administration of sulfapyridine to mice or on culture media. Fleming[7] showed that sulfapyridine added in vitro, in concentrations that could be obtained therapeutically, would greatly increase the killing power of normal blood against pneumococci and streptococci. Similar observations were observed by Lockwood.[13]

Evans and Gaisford[8] reported the first clinical results, in the Lancet, in 100 cases of pneumonia with a similar number as controls. They, however, did not specify the type of pneumonia, lobar or broncho, neither did they type the organism nor confirm the diagnosis by X-rays. They had a mortality rate of 8% in the treated cases and 27% in the controls and concluded that the drug had a beneficial effect on the course of the disease. Dyke and Reid[9] reported eight cases of lobar pneumonia with no deaths and drew the same conclusions.

Barnett et al[5] used the drug on forty infants at the St. Louis Children's Hospital who had pneumonia. They felt that, although there was no reduction in the mortality rate, the rapid drop in temperature and the rapid clinical improvement was not the usual picture of the pneumonic child.

Flippin et al,[5] in the same journal, treated 100 pneumococcal pneumonias with excellent results. These cases showed rapid drop in temperature and rapid clinical improvement. Their mortality rate was 4%. They concluded that the drug was an effective agent in the treatment of pneumococcal pneumonias and that if the drug is used carefully it is a therapeutic agent with a satisfactory margin of safety.

Anderson et al[10] had a series of 50 cases and 50 controls. They had one death in the treated series and eight in the controls. They drew similar conclusions.

Agranat et al[11] used the drug in a large series—280 cases treated with the drug and 270 as controls. In the treated series there were 10 deaths compared to 27 deaths in the control group. They concluded that, when the drug was used, the pyrexial period was much shorter, clinical course milder and the period of convalescence was reduced.

Wilson et al[12] had 35 treated cases and 35 as controls all in children or infants. There were no deaths in either series. However they concluded: 1. The drug apparently shortened the course by approximately 3-4 days. (Temperature fell earlier and clinical recovery was earlier.) 2. No correlation between blood level and effect, but that 4 mgms. level is therapeutically adequate. 3. Blood level varies with the individual and the dosage. 4. Drug is of apparent low toxicity. 5. No difference in time of X-ray clearance in either group. Other diseases caused by pneumococci and other organism have been treated with this preparation. Barnett[5] treated eleven cases of bronchitis, because of contact with pneumonia cases or because pneumococci were found in the aural discharges. All cases showed a rapid fall in temperature and rapid clinical improvement. He also had two cases of pneumococcic empyema both of which showed rapid drop in temperature, decreased toxicity and general improvement. He thought that the fluid thickened more slowly than usual and found that the cultures remained positive for pneumococci. Thoracotomy was necessary for cure.

He also treated one case of pneumococcal peritonitis with recovery, three cases of pneumococcal meningitis with two deaths and one recovery, one case of pneumococcal pericarditis with recovery but felt that the drug was of questionable value in this case. One case of sub-acute bacterial endocarditis had clinical improvement, with normal temperature and sterilization of blood stream fairly quickly and patient still alive at time of writing. Two cases of influenzal meningitis died while receiving the drug. In his miscellaneous group which included staphylococcal infections, dystenteries and tuberculous meningitis, no beneficial results were obtained. Long[4] noted rapid sterilization of the blood in three out of five cases of staphylococcal septicemia. Dimson, quoted by Long, had a prompt recovery in a chronic meningococcemia and McQuaide treated six cases of meningococcal meningitis successfully. Durel, quoted by Long, found it to be as effective as sulfanilamide in gonococcal infections.

Since this drug is a combination of sulfanilamide and pyridine, both of which produce toxic effects, it is not surprising that toxic manifestations have

CHART I

	1	2	3	4	**5**	6	7	8	9	10	11	12	13	14	15	16	**17**	18	19	20	21	22	23	24	25	COMMENTS
Name	V. M.	F. G.	P. H.	A. B.	J. K.	E. M.	H. H.	T. M.	C. M.	E. L.	F. B.	O. P.	J. L.	S. G.	M. K.	A. B.	E. B.	J. W.	J.J.H.	I. C.	C. O.	L. T.	S. S.	A. R.	E. B.	
Sex	M	F	'	M	M	F	M	M	F	F	F	M	F	F	F	M	M	F	F	M	F	M	M	M	M	12 M. 11 F.
Age	15	30	40	49	38	42	39	46	60	60	54	59	79	40	65	33	59	24	59	58	13	20	25	3 mo.	7 mo.	13 to 79 Av. 43.7
Distr.	R. M.	L. L.	L. L.	L. L.	R. U. R. M. R. L.	R. U.	R. L.	R. L.	L. L. R. L.	L. L.	R. U. R. M. R. L.	L. U.	R. L.	R. L. L. L.	R. L. R. U.	R. U. R. M. R. L.	R. L.	L. L.	L. L.	L. U. L. L.	L. U. L. L.	R. U. R. M. R. L.	L. U. L. L.	R. U.	L. L.	10 equaled **(1 plus)**
Type	VIII		XXVII	I	II	VIII	II	XXXI	III	III	I	III	IV		XVIII	I	XVIII	I	VIII	III		I	II			I II III IV VIII XVIII XXVII XXXI 5 3 4 1 3 2 1 1
BL-Cult. Pos.				**I**	**II**				**III**			**III**					**XVIII**									**1 1 2 1**
Duration Before R	1	5	3	5	7	4	1	5	4	3	8	3	2	3	4	1	?	2	2	3	1	2	2	3	3	1-8 Av. 3.3
Total Dosage	295	210	225	345	195	360	230	270	225	360	225	385	225	445	700	645	195	225	160	225	465	325	325	42½	56	160-700 Av. 317
Blood Level. Sulf.									3.7 4.0	3.2 3.8		2.4 2.3	6.1	1.8 2.8 4.0	7.7 11.6	3.6 6.6	4.7				2.3 3.2	3.2 4.1	2.1 3.5			1.8 to 7.7 Av. 4.1 in 24° 2.8 to 11.6 Av. 5.2 in 48°
W. B. C. Diff.	26/88 8/50	20/89 4/50	20/88 10/48	21/90 8/60	19/90	41/80 10/	19/70 9/	12/84 7/	18/90 9/	13/33 9/	35/87 14/	**9/86** **7/49**	39/86 13/	22/86	33/86	22/85 11/	**4/82** **3.6/**		22/94		30/86 15/78	23/88	30/85 10/76	25/84	32/96	13 to 41 except Case 12 and 17
R. B. C. Hb.	**4/90** **4/70**	**4.8/80** **4.5/80**	**4.8/85** **4.4/88**	**4.8/90**	**5.5/90**	**3.9/95**	**4.2/75**	**5.2/95** **4.5/**	**4.4/90**	**3.3/90** **5.2/**	**4.2/80**	**1.6/100**	**4.1/78** **3.2/60**	**4.8/85**	**4.7/95** **4.5/90**	**4/82**	**4.2/18**				**5/95**	**4.2/85**	**4.8/90**		**3.2/65**	Slight reduction, not significant
CO_2	53			54	48		55																			No significant change
Chlorides	460	450		380	410		430																			No significant change
Toxic Manifest.	N. V.	N. V.	N. V.	N. C.	N. V. D.	N. V C.	N. V.	N.						N.												
Temp. Normal Hrs.	24	24	24	96	**24**	48	48	48	72	48	24	48	48	72 144	48	48	**48**	24	48	48	24	48	24	24	24	24° 48° 72° 72+° 7/ 11/ 2/ 1/
Total Hosp. Days	9	11	17	28		12	7	8	14	10	13		14								14	15	10	7	7	7 to 28 Av. 13

been observed. The earliest and most annoying were nausea, vomiting and severe occipital headache. These appeared promptly after the drug was administered. By crushing the tablets and giving with milk, these manifestations have practically disappeared in our small series of cases. Thermal reactions which may confuse the picture have been reported. The temperature usually falls to normal when the drug is stopped. Skin rashes similar to those seen in sulfanilamide therapy have been reported. They are usually measly in character and generalized in extent. They disappear when the drug is stopped. Cyanosis has been noted in a number of cases but is not as marked as in sulfanilamide therapy and apparently is of no clinical significance. In a few instances more serious reactions have been reported, such as granulocytopenia and hemolytic anemias; less common are acute hepatitis, anuria, hematuria and cerebral manifestations.

More recently the sodium salt of the drug has been used. It being more soluble is supposed to result in a quicker and more adequate blood level. It has been used by Barnett by rectum in a 2% solution. Marshall found that it was more toxic to mice than was sulfanilamide. We have had no experience with it.

As a result of the encouraging report of Evans and Gaisford,[8] it was decided to observe the effect of sulfapyridine in the treatment of pneumococcus pneumonia on patients admitted to the Medical Service of the Memorial Hospital, Pawtucket, R. I. from January 1, to April 1, 1939.

This report comprises a series of twenty-five cases consisting of twenty-three adult patients and two infants. Although we originally intended to observe a control group in which other treatment was used such as serum alone or in conjunction with sulfapyridine, we decided to exclude this group from our series because we wished to observe the effect of sulfapyridine in as large a group of cases as possible during the winter months. Furthermore, our preliminary observations with the use of sulfapyridine alone were so encouraging that we did not wish to deprive any patients of the benefit of this drug.

Except for two infants, the patients consisted of twelve males and eleven females. The ages ranged from thirteen to seventy-nine years, the average age being 43.7 years.

The diagnosis in each case was based on a satisfactory history together with physical, laboratory and X-ray findings consistent with pneumonia.

Ten cases or 43.5% showed involvement of more than one lobe. Most of the patients were quite toxic and appeared seriously ill.

Sputum examination revealed type specific pneumococcus in twenty of these cases, covering eight different types, divided as follows: Five type I, three type II, four type III, one type IV, three type VIII, two type XVIII, one type XXVII, and one type XXXI. In those cases in which specific type pneumococcus was not discovered in sputum or blood stream, the history and clinical evidence was so typical that we felt rather certain that we were dealing with pneumococcus pneumonia.

Five of our patients, approximately 22%, had positive blood cultures, one type I, one type II, two type III, and one type XVIII.

The patients were not seen too early in the course of their disease, the duration of illness before beginning of treatment ranging from one to eight days, with an average of 3.3 days.

The sulfapyridine was furnished through the courtesy of Merck & Company, in seven and a half grain tablets and the following dosage schedule was followed: 30 grains were administered as an initial dose, followed by 15 grains every four hours, day and night, the total dosage ranging from 160 to 700 grains with an average of 317 grains, and with the exception of four cases, the total dosage was less than 400 grains.

In the beginning, there was some difficulty encountered in administering the medication as most of four patients objected to the drug on account of nausea, vomiting and gastric distress, but when the tablets were crushed and suspended in milk, the patients found it less disagreeable and offered no objection to the medication. In general, the medication was discontinued after the temperature was normal for 48 hours.

Blood level concentrations for sulfapyridine were made in those cases indicated, twenty-four and forty-eight hours after beginning treatment. At the end of twenty-four hours, the sulfapyridine blood levels ranged from 1.8 to 7.7 mgms. per 100 c.c., the average being 4.1 mgms. per 100 c.c. At the end of forty-eight hours, the range was from 2.8 to 11.6 mgms. per 100 c.c., the average being 5.2 mgms. per 100 c.c.

With the exception of two cases, all our patients showed a leukocytosis ranging from 13,000 to 41,000 white blood cells per cubic millimeter; the differential counts showed 72% to 94% polynuclear cells. With clinical improvement, there was an expected decrease in the white blood count and polynuclear cells but in no case was there any significant alteration noted. Following treatment there was a slight but not remarkable decrease in the red blood cells and hemoglobin. CO_2 combining power and blood chlorides were done on several of our patients. There was, however, no significant or marked deviation from the normal.

Our patients showed relatively few toxic manifestations which could be attributed to to the medication. The early cases showed mostly nausea and vomiting. One case showed some delirium. The later cases, however, showed practically no toxic manifestations and were quite free from nausea and vomiting, due either to a more purified form of the drug or to a difference in the mode of administration, the medication in the later cases being suspended in milk. Cyanosis, observed in three cases, was not marked.

The response to treatment was quite dramatic in most of our cases, beginning almost immediately with clinical improvement and an associated drop in temperature and pulse rate followed by an uneventful rapid recovery. Seven cases or approximately 30% showed a return to normal temperature within twenty-four hours. Eleven or approximately 48% showed a return to normal temperature within forty-eight hours, two within seventy-two hours, and only one after seventy-two hours. There were two deaths out of the twenty-five patients. The total hospital days ranged from seven to twenty-eight days, the average being thirteen days.

Case No. 12 (Chart B). O. P. Male, age 59.
Pneumonia left upper lobe, 3 days duration, type III sputum and blood culture, extremely toxic. W. B. C. 9000/86% polys. Total dosage 386 grains, blood concentration 2.3 mg. Temperature normal within 48 hours.

Case No. 15 (Chart B). M. K. Female, age 65.
Type XVIII pneumonia right lower lobe, duration 4 days, improved within 48 hours, auricular fibrillation, responded to digitalis; sulfapyridine discontinued when fibrillation noted, and subsequent extension to right upper lobe; sulfapyridine readministered with good recovery, concentration 7.7 and 11.6 mg. total dosage 700 grains.

Case No. 14 (Chart C). S. G. Female, age 40.
Pneumonia right lower, left lower lobes, 5 days duration, sulfapyridine for 1 day, apparent improvement, concentration 1.8. Medication discontinued because no drug available at that time, subsequent temperature rise, drug later readministered and patient again showed satisfactory response, blood concentration 2.8-4.0 mg.

Case No. 5 (Chart E). J. K. Male, age 38.
Pneumonia right upper, middle, lower lobes, 7 days duration, type II sputum and blood stream, extremely toxic and appeared moribund on admission. Total dosage 195 grains, died within 24 hours. Autopsy showed involvement entire right lung and empyema right pleural cavity.

Case No. 17 (Chart E). E. B. Male, age 59.
Pneumonia right lower lobe, duration unknown, type 18 sputum and blood stream, total dosage 195 grains, concentration 4.7 mg., extremely toxic and appeared moribund on admission. W. B. C. 4,000/82% polys., showed some temporary improvement; sudden rise of temperature to 107, died within 48 hours of admission.

The following are two infants not treated on the Medical Service but seen in consultation and recommendations and observations made by us.

Case No. 24 (Chart D). A. R. Male infant, 3 months.
Pneumonia right upper lobe, 3 days duration, dosage 3¾ grains every four hours, total dosage 42½ grains. Temperature normal within 24 hours.

Case No. 25 (Chart D). E. B. Male infant, 7 months.
Pneumonia left lower lobe, 3 days duration, dosage 3¾ grains every 4 hours, total dosage 56 grains. Temperature normal within 24 hours.

Comments

As previously indicated this group of patients presented a rather toxic relatively advanced age group admitted on an average of 3.3 days after onset of illness and treated with sulfapyridine plus the usual nonspecific supportive treatment used in pneumonia. We did not encourage the use of other medications together with sulfapyridine but several of our patients received small doses of aspirin, codeine, morphine, phenobarbital and bicarbonate of soda with no apparent harmful effect. Although our patients were treated with a uniform dosage schedule, there was considerable variation in blood level concentration of free sulfapyridine due prob-

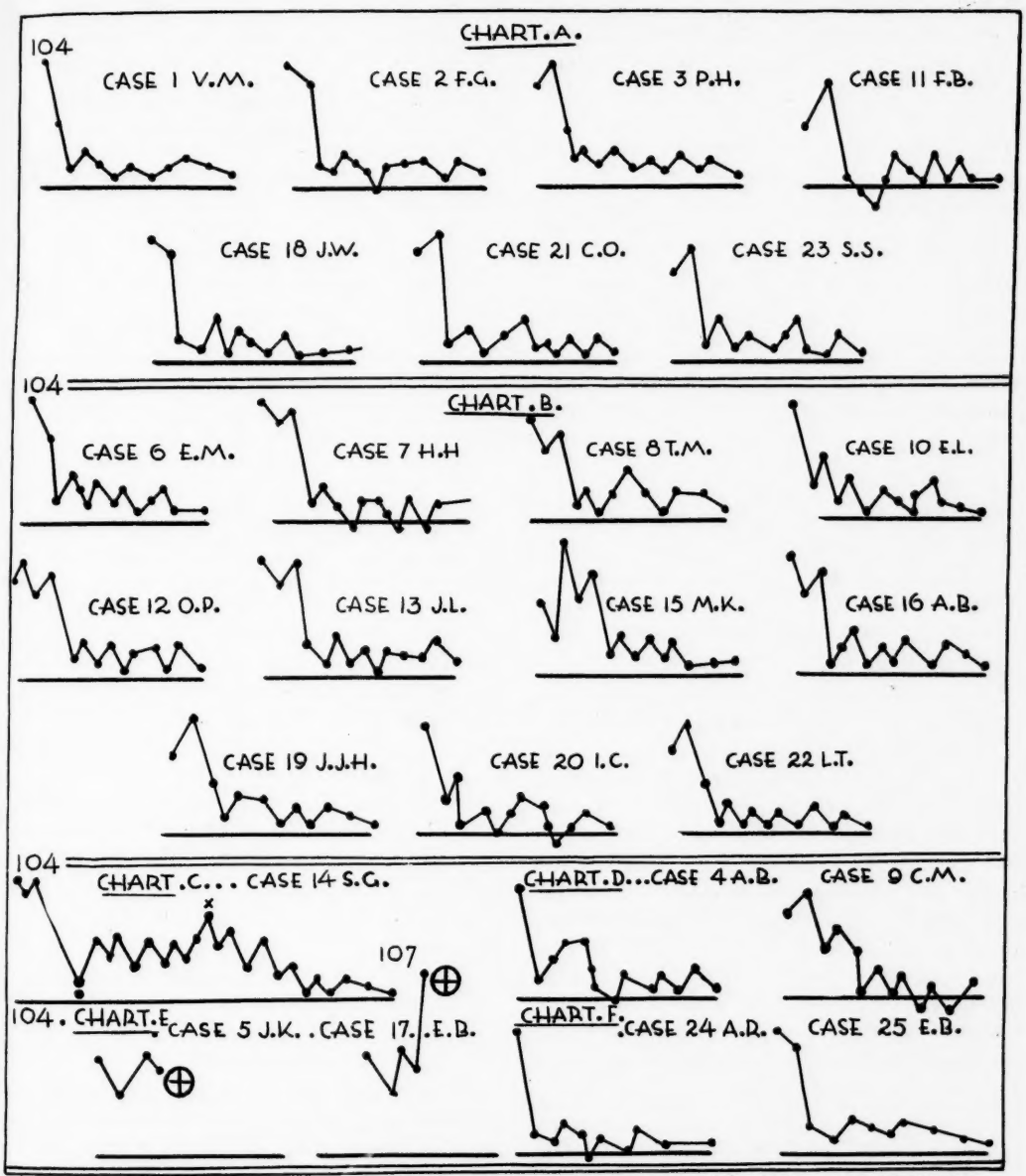

CHART A...SEVEN CASES SHOWING CRITICAL DROP IN TEMP. WITHIN 24 HRS. PULSE AND RESPIRATION IN PROPORTION. .

CHART B...ELEVEN CASES SHOWING CRITICAL DROP IN TEMP. WITHIN 48 HRS. CASE NO.12 TYPE 3 BLOOD CULTURE. . . .

CHART C...DRUG DISCONTINUED IN 24 HRS. SUBSEQUENT TEMP. RISE. READMINISTERED (x) AND PATIENT SHOWED SATISFACTORY RESPONSE. .

CHART D...CASE NO.4. TYPE 1 BL. CULT. .CASE NO.9 TYPE 3 BL.CULT. .INITIAL RESPONSE TEMP. NORMAL IN 72 HRS. . . . .

CHART E...CASE NO.5. TYPE 2 BL.CULT. . DURATION 7 DAYS. . DIED WITHIN 24 HRS. CASE NO.17. DURATION UNKNOWN. .TYPE 18 BL.CULT. . LEUCOPENIA ON ADMISSION. . DIED WITHIN 48 HRS. .

CHART F...TWO INFANTS SHOWING EXCELLENT RESPONSE TO SULFAPYRIDINE WITHIN 24 HRS

ably to irregular absorption and excretion and to irregular formation of the conjugated form (acetylation). Spectroscopic examinations for methemoglobinemia or sulphemoglobinemia were not carried out.

The response to treatment was satisfactory in all but two of our cases, which have been discussed in detail, both showing a positive blood culture and having had unusually long delay before treatment was begun. In our series, those patients who had a bacteremia, while showing a good initial response to therapy, did not reach and maintain a normal temperature in less than 48 to 72 hours. Incidentally there were four cases of type III pneumonia, two with bacteremia, all of which recovered.

It is interesting to note that there appeared to be no relationship between blood level concentration and response to therapy. We are unable to say what the optimum blood level concentration should be but apparently our average of 4-5 mgms. of free sulfapyridine per 100 c.c. appears to be satisfactory.

We have observed that in those cases in which the sulfapyridine has been discontinued too early, there has been a subsequent rise in temperature, which has required a longer period of time to return to normal. It appears therefore that the drug should be continued for at least 48 hours after the return to normal temperature.

As our experience with the use of sulfapyridine, preceded, followed or used in conjunction with type specific serum, has been limited to only a few cases, we are unable to say whether there is any advantage in the use of serum in conjunction with sulfapyridine although, inasmuch as the action of sulfapyridine appears to be bacteriostatic, it seems reasonable to believe that those cases that do not show a satisfactory antibody response with sulfapyridine alone might be aided by the additional use of serum.

Although our cases showed relatively few toxic manifestations referable to the medication, nevertheless we feel that this drug, while having a decided beneficial effect in the treatment of pneumonia, should not be given indiscriminately or without regard to the possible toxic manifestations. From our observations it appears that the nausea and vomiting is probably due to gastric irritation, although some observers feel that it is of central origin. We have certainly had less difficulty in this respect when the medication was suspended in milk.

Because of the variability of the blood concentrations and the possibilities of getting too little with impaired therapeutic effect or too much with possible toxic manifestation we feel that blood determinations should be made in all cases.

Although an alternate simultaneous control series was not made, it is interesting to note our mortality statistics for pneumonia at this hospital for the past five years, which showed a mortality rate ranging from 25% to 37%, the average being 31%. This is also true of any consecutive series of 25 cases treated at this hospital or any series of cases treated from January to April, covering the same seasonal period as our series. We have personally observed most of the cases during the past five years, and feel that they did not present any sicker group than those treated this year. Certainly our results with sulfapyridine are extremely encouraging.

Conclusion

Sulfapyridine is an effective therapeutic drug in the treatment of pneumococcus pneumonia, causing a decrease in the mortality and morbidity of this disease and shortening the convalescent period. It appears to be a relatively safe therapeutic agent, but should be used with caution with regard to its toxic possibilities.

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CHARLES H. HOLT, M.D.

President of the Rhode Island Medical Society — 1939-1940

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THE RHODE ISLAND MEDICAL JOURNAL
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THE CONSULTATION

It is a fact that the majority of patients receive more than adequate care by their respective physicians or surgeons and that the courses of their illnesses run uneventfully to a satisfactory recovery. It is also a fact that some cases are irregular in their respective courses so that they are either puzzling as to the diagnosis or fail to respond to the therapy afforded them. It is to these irregular types of cases that the consultation is of value.

Webster defines the consultation as a deliberation between two or more physicians concerning the diagnosis of the disease of the patient and the proper method of treatment. The consultation yields many advantages to all concerned—especially to that most important individual—the patient.

It is to the patient's advantage that the possibility of error in diagnosis and treatment is diminished by at least fifty per cent by this procedure. It is a source of satisfaction to the patient in that it removes any doubt from his mind as to the diagnosis and the advisability of treatment. And it is to the patient's advantage to have the opinion of one who has probably seen many similar cases and their outcome.

It is to the family doctor's advantage to have the possibility of error in diagnosis and treatment lessened to a great degree and to have a brother M.D. share the responsibility of the diagnosis and the course of treatment. The family doctor's knowledge as to cases of the type concerned is increased. The consultation is also of benefit to the family doctor in that it greatly increases his patient's confidence and esteem.

The consultation is of advantage to the consultant in that it contributes to his knowledge in his particular field of medicine. It gives him a share in the responsibility for the diagnosis and treatment of the patient. It adds to his prestige and professional standing in his particular branch of medical field.

ANNUAL MEETING

The Committee of Arrangements for the Annual Meeting of the Rhode Island Medical Society deserve the congratulations and thanks of the members. Time was when these meetings were not as good as they should be. This year both clinics and papers were given on timely and important subjects, the presentations were very good and in many instances of unusual excellence and altogether the meeting was thoroughly worth while.

There are two interesting points that deserve some thought. The attendance, except for the evening meetings, was not as good as the quality of the program would lead one to expect. We believe that there should be more advance publicity in local medical associations, in the Rhode Island Medical Journal and through the mail, and that before the meeting a program as detailed as possible should be mailed to each member. Such publicity would undoubtedly increase the attendance.

Another factor in the situation is the failure of many physicians to join the Rhode Island Medical Society. The total membership is 492, just over 50% of the physicians of the State. The time has come to make all members of the District Associations automatically members of the State Society. These men should realize that the State Society, which upholds the cause of medicine at the State House and at Washington, needs their support. The scientific and social activities of the Society give them full value for their dues.

RHODE ISLAND MEDICAL SOCIETY

Minutes of the One Hundred and Twenty-eighth Annual Sessions

Meeting of the Council

The annual meeting of the Council of the Rhode Island Medical Society was held at the Medical Library, Thursday, May 18, 1939. The meeting was called to order by the President, Dr. Edward S. Brackett, at 4:30 P. M. Present were Drs. Brackett, Hammond, DeWolf, Wheaton, George S. Mathews, Partridge, Donley, J. P. Jones, Holt, Fulton, Wing, Hussey, Mowry and Miller. In the absence of the Secretary, who was representing the Society at the St. Louis convention of the American Medical Association, Dr. Miller was appointed Secretary pro tem.

The Secretary read the records of the Council meeting of January 19, which were approved and placed on file. The report of the Treasurer was read by Dr. Jesse E. Mowry. It was received and placed on file. On motion of Dr. Mowry, seconded by Dr. Partridge, Drs. Frank S. Hale and J. P. Lobe were reinstated as fellows of the Society. The resignation of Dr. James P. Londergan was accepted. On his request, Dr. A. Sammartino was suspended temporarily from fellowship in the Society. It was voted that Drs. M. Messerlian and C. S. Ducet be reinstated to fellowship on payment of dues.

Responding to the request of the Council, Dr. Harry C. Messinger, Chairman of the Committee on Publication, reported on the condition of the *Rhode Island Medical Journal* and recommended that an appropriation of $486.00 be made for its support. Dr. Partridge moved that the Society support the Journal. The question was discussed by Drs. Hammond, Mowry, Brackett, Donley, Miller and Messinger. On motion of Dr. DeWolf, duly seconded, it was voted to appropriate $243.00 for support of the *Journal.*

The meeting was adjourned at 5:35 P. M.

Respectfully submitted,

ALBERT H. MILLER, M.D.,
Secretary pro tem.

Meeting of the House of Delegates

The annual meeting of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library, Thursday, May 18, 1939. The meeting was called to order by the President, Dr. Edward S. Brackett, at 5:40 P. M. In the absence of the Secretary, Dr. Miller was appointed Secretary pro tem.

The report of the Nominating Committee was read by Dr. Hammond. As there were no counter nominations, on motion of Dr. Mowry, by unanimous consent, the Secretary cast one ballot for the candidates recommended by the Nominating Committee. They were declared elected as the officers for the ensuing year.

The Secretary then read the minutes of the meeting of the Council of even date. Dr. Mowry read the report of the Treasurer. Dr. Miller read the report of the Secretary. The report of the Committee on Arrangements was read by Dr. Dimmitt. The report of the Committee on Legislation was presented by Dr. Harris. The Secretary read the report of the Library Committee. The report of the Committee on Publication was read by Dr. Messinger. Dr. Eddy presented the report of the Committee on Education. Dr. Woodmansie presented the report of the Committee on Necrology. The Secretary read the reports of the Committees on Publicity and on Annual Commercial Exhibits. He next read the reports of the Committees on Annual Clinics and on Cancer. Dr. Wing presented the report of the Committee on Hospitalization Insurance. Each of these reports was accepted and placed on file.

On motion of Dr. Burgess, seconded by Dr. Hammond, Dr. Brackett was elected a member of the Executive Board of the Hospital Service Corporation of Rhode Island, for a term of three years.

Dr. Hussey then read the report of the Committee on State Policies of Public Health. Dr. Hammond presented the report of the Committee on Social Security. Dr. Walsh presented the report of the Committee on Maternal Mortality. The report of the Committee on Child Health was read by Dr. Utter. Each of these reports was received and placed on file.

Under the head of new business, the matter of W.P.A. workmen being referred to government hospitals for treatment was referred to the Committee on Social Security.

The meeting was adjourned at 6:50 P. M.

Respectfully submitted,

ALBERT H. MILLER, M.D.
Secretary pro tem.

Annual Report of the Treasurer

J. W. C. Ely Fund

January 1, 1938		January 1, 1939	
37 shares Rhode Island Public Service Co.	$1,071.67	37 shares Rhode Island Public Service Co.	$1,071.67
Interest	74.00	11⅕ new shares Common Stock, Mechanics Nat. Bank	280.00
11⅕ new shares Common Stock, Mechanics Nat. Bank	280.00	Paid Rhode Island Medical Society for Journals	74.00
Interest in default			
	$1,425.67		$1,425.67

Endowment Fund

January 1, 1938		January 1, 1939	
16 shares National Bank of Commerce & Trust Co.	$1,200.00	16 shares National Bank of Commerce & Trust Co.	$1,200.00
Interest	48.00	74 shares Providence Gas Co.	906.50
74 shares Providence Gas Co.	906.50	Peoples Savings Bank	3,419.96
Interest	44.40		
Peoples Savings Bank	3,245.92		
Bank interest	81.64		
	$5,526.46		$5,526.46

E. M. Harris Fund

January 1, 1938		January 1, 1939	
2,000 A-NY & B-NY Realizing Corp. Debentures 5½%	$2,000.00	2,000 A-NY & B-NY Realizing Corp. Debentures	$2,000.00
4 shares stock A-NY & B-NY Realizing Corp. No interest in 1938		4 shares stock A-NY & B-NY Realizing Corp.	
2,000 General Public Utilities Co. 6½%	1,980.00	2,000 General Public Utilities	1,980.00
Interest	156.00	26 shares Nicholson File Co.	1,040.00
26 shares Nicholson File Co.	1,040.00	Paid Rhode Island Medical Society for Repairs on Building	210.60
Interest	54.60		
	$5,230.60		$5,230.60

Frank L. Day Fund

January 1, 1938		January 1, 1939	
3,000 Canadian National Railway Co. 4%	$2,979.75	3,000 Canadian National Railway Co.	$2,979.75
Interest	135.00	Paid for Medical Books	73.05
Industrial Trust Company	448.48	Industrial Trust Company	510.43
	$3,563.23		$3,563.23

Herbert Terry Fund

January 1, 1938		January 1, 1939	
96 shares Providence Gas Co.	$1,152.00	96 shares Providence Gas Co.	$1,152.00
Interest	57.60	Paid Rhode Island Medical Society for Journals	57.60
	$1,209.60		$1,209.60

James R. Morgan Fund

January 1, 1938		January 1, 1939	
43 shares Providence Gas Co.	$ 526.75	43 shares Providence Gas Co.	$ 526.75
Interest	25.80	Paid Rhode Island Medical Society for Expenses	25.80
	$ 552.55		$ 552.55

James H. Davenport Fund

January 1, 1938		January 1, 1939	
89 shares Providence Gas Co.	$1,068.00	89 shares Providence Gas Co.	$1,068.00
Interest	53.40	Balance on hand	505.33
Balance on hand	451.93		
	$1,573.33		$1,573.33

Cataloguing Fund

January 1, 1938		January 1, 1939	
Peoples Savings Bank	$ 139.32	Peoples Savings Bank	$ 142.82
Interest	3.50	Providence National Bank, Checking Account	195.57
Providence National Bank	208.07	Paid out during 1938	12.50
	$ 350.89		$ 350.89

Participation Account

January 1, 1938		January 1, 1939	
Providence Institution for Savings	$ 567.38	Providence Institution for Savings	$ 580.93
Interest	13.55		
	$ 580.93		$ 580.93

RECEIPTS

Cash on Hand January 1, 1938	$1,734.48
Annual Dues	4,162.50
Donations	690.10
Harris Fund	210.60
Terry Fund	57.60
Davenport Fund	53.40
Ely Fund	74.00
Morgan Fund	25.80
Endowment Fund interest transferred to Peoples Savings Bank	92.40
Exhibits, Annual Meeting, Donations	365.00
	$7,465.88

EXPENDITURES

Collation and Annual Dinner Expenses	$ 681.00
Expenses of Secretary, Secretary Service, etc.	90.00
Printing and Postage	137.43
Gas	42.15
Electricity	73.38
Fuel	523.00
Telephone	113.35
City Water	18.36
House Supplies and Expenses	264.45
House Repairs	198.71
Librarian	1,660.00
Janitor	780.00
Journals, Ely and Terry Funds	73.50
Safe Deposit	6.60
Treasurer's Bond	25.00
Dues, Medical Library Association	10.00
Delegate, American Medical Association	100.00
Sunday Lectures	132.32
Endowment Fund interest transferred to Peoples Savings Bank	92.40
Expenses, Publicity Committee	28.20
	$5,049.85
Cash on Hand to Balance	2,416.03
	$7,465.88

Respectfully submitted,

JESSE E. MOWRY, M.D.,
Treasurer.

Examined and found correct, May 17, 1939.
HAROLD L. COLLOM, M.D.
J. MURRAY BEARDSLEY, M.D.

Report of the Nominating Committee

The Nominating Committee appointed by the President to submit to the House of Delegates, a list of Officers and Standing Committees for the ensuing year, begs leave to report as follows:

President:
Charles H. Holt, Pawtucket

First Vice President:
Lucius C. Kingman, Providence

Second Vice President:
Frederic V. Hussey, Providence

Secretary:
Guy W. Wells, Providence

Treasurer:
Jesse E. Mowry, Providence

Legislative, State and National
Herbert E. Harris, Providence
Charles F. Gormly, Providence
Earl F. Kelly, Pawtucket
The President and Secretary, ex-officio

Publication
Charles S. Christie, West Warwick
John E. Donley, Providence
Charles J. Ashworth, Providence
The President and Secretary, ex-officio

Education, State and National
Jesse P. Eddy, 3rd, Providence
Thad A. Krolicki, Pawtucket
Frank B. Cutts, Providence
The President and Secretary, ex-officio

Library
Herbert G. Partridge, Providence
Andrew W. Mahoney, Providence
Samuel Adelson, Newport

Necrology
Harry F. Crandall, Westerly
Guyon G. Dupre, Woonsocket
Edward T. Streker, Providence

Arrangements
Nathan A. Bolotow, Providence
Walter S. Jones, Providence
Ralph DiLeone, Providence
The Treasurer, ex-officio

Delegate
Guy W. Wells, Providence

Alternate
Alex M. Burgess, Providence

Curator
Carl D. Sawyer, Providence

Auditors for 2 years
J. Murray Beardsley, Providence
Robert T. Henry, Pawtucket

Respectfully submitted,
LINWOOD H. JOHNSON
HENRI E. GAUTHIER
JOHN F. KENNEY
WILLIAM S. STREKER
ROLAND HAMMOND, *Chairman.*

CHARLES V. CHAPIN HOSPITAL

Dr. Robert W. Drew left June 30 to return to the Rhode Island Hospital as assistant superintendent. Dr. Genarino R. Zinno, who finished a six-month internship at the Chapin Hospital on June 30 will fill the vacancy.

Drs. Martin Glynn, Irving Blazar, Edgar S. Highberger, and Raymond E. Moore also completed internships. Dr. Moore is leaving to open an office somewhere in Massachusetts.

The new interns who commenced service on July 1 were Drs. Harry R. Kellett, E. Mansfield Gunn, Isadore Gershman, Michael DiMaio, and Walter E. Batchelder. Dr. James P. McCaffrey, a graduate of Harvard College and Tufts Medical School, 1937, will commence an internship later in the month upon arrival from a trip abroad. He has finished an internship at the Rhode Island Hospital.

Dr. Kellett, of Lawrence, Massachusetts, a graduate of Bowdoin College and Tufts College Medical School, 1938, has had a one-year internship at the Newton Hospital.

Dr. Gunn comes from Westerly, attended Rhode Island State College, and finished his studies at the Syracuse University College of Medicine this year.

The other three men are from Providence. Dr. DiMaio attended Rhode Island State College and received his degree this year from the Johns Hopkins University School of Medicine. He spent three months at the Chapin Hospital during the summer of 1938. Dr. Batchelder is a 1939 graduate of Boston University Medical School and had three months at the Rhode Island Hospital last summer. He is the brother of Dr. Phillip Batchelder who is assistant director of the X-ray Department of the Rhode Island Hospital. Dr. Gershman is a graduate of Brown University and after graduating from Jefferson Medical Collge in 1938, he accepted a one-year appointment at the Wilmington General Hospital in Delaware which ended June 30.